DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 4

2. STATE: Montana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
04/01/01

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a)(10)(E) of the Social Security Act
Section 4501(b) of OBRA 90

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ 0
b. FFY _____ $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Text pages 206 & 29
Attachment 3.1A page 2
Attachment 3.1B page 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Text pages 206 & 29
Attachment 3.1A page 2
Attachment 3.1B page 2a

10. SUBJECT OF AMENDMENT:
4 pages that were inadvertently not updated in May 1993.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Single State Agency Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gail Gray

13. TYPED NAME:
Gail Gray Ed,D

14. TITLE:
Director

15. DATE SUBMITTED:
06/28/01

16. RETURN TO:
Department of Public Health & Human Services
Gail Gray Director
Attn: Jean Robertson
PO Box 202951
Helena MT 59620-2951

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 29, 2001

18. DATE APPROVED:
8/2/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
4/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: June 28, 2001

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act

___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act

___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: MONTANA

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A X Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

State/Territory: Montana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations _X_ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations _X_ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ___ No limitations _X_ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations _X_ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: ___ No limitations _X_ With limitations*

* Description provided on attachment.

State/Territory: MONTANA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s): All medically needy

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5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ___ No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations:

*Description provided on attachment.